STATE OF CONNECTICUT
STATE TEACHERS' RETIREMENT BOARD
21 GRAND STREET HARTFORD, CT 06106-1500
In CT 1-800-504-1102 (860) 241-8414 Fax (860) 525-6018
www.ct.gov/trb

TRB SPONSORED MEDICARE SUPPLEMENTAL INSURANCE INFORMATION

ENROLLMENT REQUIREMENTS

All coverage takes effect on the first day of the month. Enrollment forms must be received by the 25th day of the second month preceding the effective date of coverage. For example, for coverage to be effective December 1st, the enrollment form must be received by October 25th. THE FIRST PREMIUM WILL BE DEDUCTED FROM THE NOVEMBER 30TH BENEFIT.

If you are a new retiree or the spouse of a new retiree, coverage can begin no earlier than two months after the effective date of retirement. A July retiree would be able to obtain coverage effective September 1st.

Complete one enrollment form per enrollee. A member and a spouse must each complete a separate enrollment form. Submit proof of Medicare eligibility either by a photocopy of your Medicare Card or a letter from Social Security stating the Medicare Claim# and the effective date of coverage. Once you enroll in a health plan through CTRB, you must remain in that plan until the next open enrollment period of January 2006.

Cancellations

A written cancellation request must be received by the 25th day of the second month preceding the effective termination date. To terminate coverage May 1st, notification must be received by March 25th. You will not be allowed to re-enroll in any of the TRB sponsored plans until the next open enrollment period.

Coverage Changes From 2004

The maximum annual out of pocket cost for prescriptions is $1,000. Upon reaching this limit, your prescriptions will be filled at no cost to you for the remainder of the calendar year.

The major medical maximum has increased to $1 million, from the present $100,000 limit.

Vision benefits increased as follows:

	Current benefit	New benefit
Single vision	$ 30.00	$ 60.00
Bi-focal	$ 40.00	$ 80.00
Tri-focal	$ 60.00	$120.00
Lenticular	$100.00	$200.00
Frames	$ 40.00	$ 80.00
Contact Lenses	$160.00	$320.00

The hearing aid reimbursement has increased from $500.00 to $750.00.

The elimination of the additional 120 days of coverage in a Skilled Nursing Facility after the Medicare benefit of 100 days has been exhausted.

Prescriptions

An annual $250.00 deductible is required for all members of the plan. The Mail Order Co-Pays are 15% for generic, 20% for brand name formulary drugs and 30% for brand name non-formulary drugs. The Retail Pharmacy Co-Pays are 20% for generic, 25% for brand name formulary drugs and 35% for brand name non-formulary drugs. The maximum out of pocket cost is $1,000 per year. When this limit is reached, you will obtain your prescriptions at no charge for the remainder of the year.

Claims/Coverage

Hospital and Medical Coverage are administered by the Board's Claim Administrator, Stirling & Stirling. Prescription Drug Benefits are administered by Paid Prescriptions - Merck-Medco. Dental Benefits are administered through the Delta Dental Plan of New Jersey. For questions regarding enrollment contact Teachers' Retirement @ 800-504-1102 ext 8414, or 860-241-8414.

When filing claims, please be aware that retirees and spouses enrolled in any of our plans have individual coverage. All claims should be filed as "SELF" with your own social security number regardless of whether you are the retiree or the spouse.

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IMPORTANT NOTICE FOR TRB HEALTH INSURANCE PLAN

PREMIUM CHANGE DEFERRAL ANNOUNCEMENT
JANUARY 2005

The Teachers' Retirement Board (TRB) Health Plan is a self-insured health plan. The amount you have been paying for your coverage has been 25% of the budgeted premium amount for the TRB plan. The State of Connecticut also pays 25% and the health fund pays the remaining 50%. To insure the solvency of the health plan and the availability of subsidized health insurance coverage through the Teachers' Retirement System, Public Act 03-232 was passed to change the amount you pay for your health coverage (your contribution towards the premium) from 25% to 33% effective July 1, 2005. The State of Connecticut's portion will also increase from 25% to 33%. The remaining 33% will be paid for from the health insurance fund. Although annual premium increases normally occur on January 1st of each year, the Board Members governing the Teachers' Retirement System voted to defer this increase until July 31, 2005, when the 33% member contribution takes effect. The rate will be inflated due to the amount owed for the period December 31, 2004 thru June 30, 2005.

Your opportunity to change coverage remains October of 2004 for an effective date of January 1, 2005, or October of 2005 for an effective date of January 1, 2006. You will not be given an opportunity to change your coverage when the premium change takes effect on July 31, 2005. Please review your options carefully at this time, as you will be locked into your decision for the 2005 calendar year.

Member's monthly cost for 2005	**12/31/04 - 06/30/05**	**07/31/05 - 11/30/05**
Medicare Suppl with Prescriptions	$51.00	$ 89.00
Medicare Suppl with Prescriptions & Dental	$84.00	$128.00
Medicare Suppl with Prescriptions, Dental, Vision & Hearing	$88.00	$132.00

Insurance premiums are paid on the last day of the prior month for coverage effective on the 1st day of the next month.

There are no coverage or limit changes for 2005.

Health Coverage Change Requirements

Two change forms are enclosed with this notice. If a member and a spouse both have changes, you must each complete a separate form. **Forms must be received in this office by October 25, 2004.**

PLEASE RETAIN THIS DOCUMENT

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MEDICARE SUPPLEMENTAL HEALTH INSURANCE ENROLLMENT FORM

Medicare Part A and Part B must be your primary insurance.

A PHOTOCOPY OF YOUR MEDICARE CARD OR A LETTER FROM SOCIAL SECURITY CONTAINING THE MEDICARE CLAIM # AND EFFECTIVE DATE OF COVERAGE IS REQUIRED.

ONE FORM PER ENROLLEE MUST BE RECEIVED BY THE 25TH OF THE 2ND MONTH PRECEDING THE EFFECTIVE DATE OF COVERAGE.

Once you enroll in a plan, you may not add or drop coverages until the next coverage change period, held each January.

I ELECT TO HAVE THE FOLLOWING COVERAGE BECOME EFFECTIVE _____ /01/ _____.

	Cost per person per month Jan–July	Aug-Nov	Check one(x)
Medicare Supplement with Prescriptions	$51.00 monthly	$ 89.00	☐
Medicare Supplement with Prescriptions and Dental	$84.00 monthly	$128.00	☐
Medicare Supplement with Prescriptions and Dental, Vision & Hearing	$88.00 monthly	$132.00	☐
Cancel all TRB coverage			☐

ALL ENROLLEES MUST PROVIDE THE FOLLOWING INFORMATION:

Enrollee's Last Name	First	Initial	Home Phone

Street Address	City	State	Zip Code

Social Security Number	Medicare Number	Date of Birth

PREMIUMS ARE DEDUCTED MONTHLY FROM THE MEMBER'S RETIREMENT BENEFIT

Enrollee's Signature	Date

If you are enrolling as the spouse of a retired teacher, please furnish the following:

Retired Teacher's Name	Social Security Number

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Cancel all TRB coverage			☐

ALL ENROLLEES MUST PROVIDE THE FOLLOWING INFORMATION:

Enrollee's Last Name	First	Initial	Home Phone

Street Address	City	State	Zip Code

Social Security Number	Medicare Number	Date of Birth

PREMIUMS ARE DEDUCTED MONTHLY FROM THE MEMBER'S RETIREMENT BENEFIT

Enrollee's Signature	Date

If you are enrolling as the spouse of a retired teacher, please furnish the following:

Retired Teacher's Name	Social Security Number